Appendix A

Glossary

The following provides brief definitions and descriptions of terms, abbreviations, and acronyms often used in the conjunction with the Medicaid program.

AI is an indicator in the CAP block on the MID card that identifies a recipient as a participant in the Community Alternatives Program for Persons with AIDS (CAP/AIDS). The participant qualifies for the ICF level of nursing facility care.

AS is the indicator in the CAP block on the MID card that identifies the recipient as a participant in the Community Alternatives Program for Persons with AIDS (CAP/AIDS). The participant qualifies for SNF level of nursing facility care.

Baby Love is a Medicaid program aimed at reducing infant mortality by improving access to health care and support services for low income pregnant women and young children. The extended coverage for pregnant women is called Medicaid for Pregnant Women (MPW) and provides pregnancy-related care. The extended coverage for children allows the child to receive all Medicaid benefits. Maternity care coordination is a key aspect of Baby Love.

Blue Card refers to the color of the Medicaid ID card issued to those persons eligible under regular Medicaid eligibility requirements.

Buff Card refers to the color of the Medicaid ID card issued to those persons eligible for Medicare-Aid, which qualifies them for some Medicare-covered services. The holders of this card are Medicare Qualified Beneficiaries (MQB). See **MQB**.

CAP is the acronym for the Community Alternatives Programs—waiver programs that provide an alternative to institutional care. The programs allow those who otherwise would be institutionalized to live in the community.

CAP/AIDS is the CAP program for persons with AIDS and children who are HIV-positive.

CAP/C is the CAP program that provides home care for medically fragile children through age 18 who otherwise would require hospital or nursing facility care.

CAP/DA is the CAP program that provides home care for disabled adults age 18 and up who would otherwise require nursing facility care.

CAP/MR/DD is the CAP program for Persons with Mental Retardation/Developmental Disabilities, which provides home and community care for persons who otherwise would require care in an intermediate care facility for the mentally retarded (ICF/MR).

Carolina ACCESS is a Medicaid program created to improve recipient access to primary care. Medicaid contracts with primary care physicians to deliver and coordinate health care. The primary care physician becomes the recipient's "care coordinator" for the delivery or arrangement of needed services.

Categorically Needy refers to persons whose Medicaid eligibility is based on their family, age, or disability status. Persons not falling into these categories cannot qualify, no matter how low their income.

CHAMPUS is Civilian Health and Medical Program of the Uniformed Services. A Department of Defense program supporting private sector care for military dependents.

CI is the indicator in the CAP block on the MID card that identifies the recipient as a participant in the Community Alternatives Program for Disabled Adults (CAP/DA). The participant qualifies for the ICF level of nursing facility care.

CM is the indicator in the CAP block on the MID card that identifies the recipient as a participant in the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP/MR/DD).

Copayment is the amount that a Medicaid recipient is responsible for paying for certain services, such as prescriptions and physician visits. Medicare also has copayments for certain services.

County DSS refers to the county department of social services—the local agency that determines Medicaid eligibility and eligibility for other assistance programs and provides many services in the county.

CS is the indicator in the CAP block on the Medicaid ID card that identifies the patient as a participant in the Community Alternatives Program for Disabled Adults (CAP/DA). The participant qualifies for the SNF level of nursing facility care.

Deductible – see Medicaid Deductible

DFS is the Division of Facility Services in the Department of Health and Human Services. The division, specifically the Licensure and Certification Section, within DHHS responsible for establishing and maintaining health standards for private and public institutions that provide service to Medicaid recipients.

DHHS is the Department of Health and Human Services (formerly **Department of Human Resources**). The single state agency charged with overall administration of human services programs and licensure of health care providers under North Carolina law.

Disproportionate Share Hospital is a hospital that serves a disproportionate number of low income people.

Division of Health Promotion is the agency within DHHS that works with DMA to provide health care services for persons with HIV and AIDS.

Division of Maternal and Child Health is the agency within DHHS that works with DMA in administration of Medicaid's Baby Love program, independent therapy practitioners program, health-related services in the public schools, and Head Start programs.

DMA is the Division of Medical Assistance. The agency within DHHS responsible for the administration of the North Carolina Medicaid program. DMA interprets federal regulations, establishes policies to ensure that Medicaid-eligible North Carolinians receive appropriate medical care, enrolls providers, and conducts quality assurance audits and reviews to ensure the integrity of program operations and provider payments. DMA also establishes reimbursement rates in accordance with the Appropriations Act, enacted by the General Assembly, and the State Medicaid Plan.

DME is the acronym for durable medical equipment.

DMH/DD/SAS is the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in DHHS. This is the agency that administers services and programs, including Carolina Alternatives and CAP/MR/DD, related to mental health, developmental disabilities, and substance abuse.

DOA is the North Carolina Division of Aging. The agency within DHHS that provides home and community-based long-term care services to the aged population. Jointly DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

DOS is date of service—the date that a service is provided to a Medicaid recipient.

DPI is the Department of Public Instruction. The state education agency responsible for ensuring that preschoolers and school-age children with handicapping conditions are provided appropriate education-related services, including medical services such as speech, physical, and occupational therapy. DPI, local school systems, the Division of Maternal and Child Health, and DMA collaborate to ensure Medicaid reimbursement is claimed for the medical services provided.

DSS is used in two ways. Used alone, it refers to the North Carolina Division of Social Services in DHHS. This is the agency that administers public assistance programs (other than Medicaid) and service programs for children and adults. When DSS is preceded by "county," it refers to the department of social services in each county in the state.

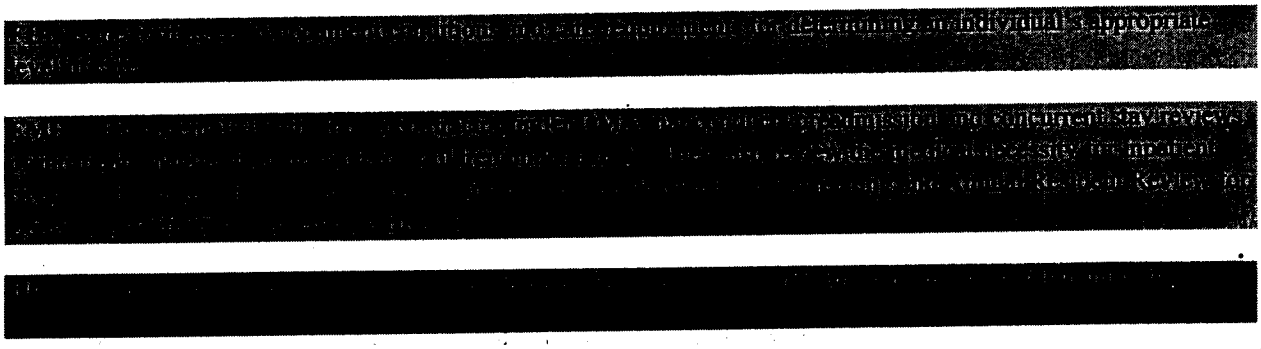
ECS is electronic claims submission—a paperless method of submitting claims to EDS.

EDS is Electronic Data Systems, the fiscal agent for DMA that handles claims processing and other responsibilities, such as prior approvals.

EFT is electronic funds transfer, the procedure for EDS to electronically transfer claims payments to a provider's bank account.

Enrollment is the method used by provider to become eligible for Medicaid payment. The provider enrolls with DMA to get a provider number that allows the provider to bill for services.

EOB is Explanation of Benefits.



HCFA is the Health Care Financing Administration, the agency that administers Medicare and Medicaid for the federal government.

HCFA-1500 is the form used by certain providers such as physicians to submit Medicaid claims.

HCPCS is HCFA Common Procedure Coding System—used to describe the billing codes (HCPCS codes).

Health Care Connection is a Medicaid managed care waiver program in Mecklenburg County.

Health Check is a preventive care program for Medicaid children ages birth through 20.

HIPP is Health Insurance Premium Payment Program, a program that pays health insurance premiums for Medicaid recipients when it is cost effective to do so and when other requirements are met.

HMO is health maintenance organization. DMA contracts with these organizations through the Health Care Connection program.

Home Health Services are designated services (e.g., skilled nursing, physical therapy, home health aide) designed to help restore, rehabilitate, or maintain a recipient who resides in a private residence. Recipients residing in an adult care home may receive all services except home health aide services.

Hospice refers to Medicaid's all-inclusive coverage of care related to a recipient's terminal illness or a provider of this type of care.

[redacted]

ICF/MR is an intermediate care facility for the mentally retarded, a licensed facility that provides care and treatment for individuals with mental retardation and certain developmental disabilities.

ICN is the internal control number assigned to a claim by EDS. On a RA, the ICN is shown as the claim number.

[redacted]

Medicaid Deductible is the amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service. Also called **spend down.**

Medicaid ID card is the card issued monthly to identify individuals eligible for Medicaid coverage. The cards are blue, pink, or buff, with each color denoting a certain type of coverage.

Medically Necessary is the term used to indicate that a patient has a medical necessity for a service. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

Medically Needy refers to persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, is below state income limits for Medicaid.

MID is the acronym for Medicaid Identification Number—the individual identification number assigned to each Medicaid recipient. It consists of nine digits and an alpha suffix.

MID Card is the Medicaid Identification Card, issued to eligible recipients on a monthly basis. The card has the recipient's MID number, dates of eligibility, and other information helpful to the provider.

MPW is Medicaid for Pregnant Women, a part of the Baby Love program to extend Medicaid coverage for pregnancy-related services to low income pregnant women who have income and resources that exceed the limits for regular Medicaid coverage.

MQB is Medicare Qualified Beneficiaries. Medicare uses **QMB.**

MRNC is Medical Review of North Carolina. MRNC operates Medicaid's preadmission review program for elective inpatient hospital care, including elective psychiatric admission for adults to general hospitals. MRNC also conducts quality assurance reviews of prepaid health plan services, the Community Alternatives Programs (CAP), nursing facilities, and health maintenance organization (HMO) contracts.

NCAC is the North Carolina Administrative Code—the state regulations.

NF is the acronym for nursing facility.

OBRA is the Omnibus Budget Reconciliation Act of 1987.

OT refers to occupational therapy or occupational therapist.

Outlier refers to a hospital admission requiring either substantially more expense or a much longer length of stay than average. Under DRG reimbursement, outliers are given exceptional treatment.

PASARR is the acronym for preadmission screening annual residents review.

PCS is Personal Care Services, a home care service that provides in-home aide services to meet the recipient's medically related personal care needs.

PDN is Private Duty Nursing, a home care service that provides continuous nursing care for patients in their homes.

Provider describes a licensed health care professional or facility enrolled with Medicaid to provide health care services to recipients. The term also refers to medical supply firms and vendors of durable medical equipment.

Provider Participation Agreement is a written contract between DMA and a Medicaid provider stating that the provider understands and will follow Medicaid policies and procedures as well as applicable laws and regulations.

PT refers to either physical therapy or a physical therapist.

QMB–see MQB

RA (Remittance Advice) refers to **Medicaid Remittance and Status Report**, a report issued by EDS that gives a provider detailed information on the status of claims.

Recipient refers to a person authorized for Medicaid coverage.

REOMB is Recipient Explanation of Medicaid Benefits, a form that DMA sends to Medicaid recipients to verify that they received the services billed to Medicaid.

Revenue code is the code used on a UB-92 to identify specific accommodation, ancillary service, or billing calculation.

SNF is the acronym for skilled nursing facility or long term care NF service.

Spend down–see Medicaid Deductible

SSI refers to Supplemental Security Income, a federal program of cash assistance for persons who are over age 65, disabled, or blind and with limited income and resources. The program is administered through the Social Security Administration.

Swing-Bed Hospital is an authorized small rural hospital that has hospital beds designated for both acute care and skilled nursing care, depending on the needs of the patient.

Third Party Liability (TPL). This refers to an entity, such as a private insurer, who is responsible for paying for part or all of the cost of a medical service.

Title XVIII (Medicare) - The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid) - The title of the Social Security Act that contains the principal legislative authority for Medicaid and therefore a common name for the program.

UB-92 is the universal billing form used by hospitals and certain other providers to submit Medicaid claims. See **HCFA-1500.**

Utilization Review is the evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities and safeguards against excessive payments. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. In nursing facilities this is performed by the utilization review committee.

Waivers are Medicaid programs with standard program requirements waived to allow the program to operate. Carolina ACCESS, Community Alternatives Program, and Health Care Connection are included in Medicaid waivers.